STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445141	A. BUILDING 01 - BUILDING #1 B. WING	06/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADLEY HEALTH CARE & REHAB	2910 PEERLESS RD CLEVELAND, TN 37312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the 1 hour fire rated construction. The findings include: Observation on June 6, 2013 at 2:00 p.m. revealed penetrations in the following locations: 1. Above ceiling at fire doors by room 418 has a penetration the in wall and the head wall joint is not sealed and fire caulked. 2. Above ceiling at fire doors by room 416, the head wall joint is not sealed and fire caulked. These findings were verified by the maintenance director and acknowledged by the administrator	K 017	1. On 6/26/13 the maintenance staff repaired the penetrations above the ceiling fire doors at room 418 and also at the fire doors by room 416. 2. On 6/26/13 the maintenance manager and staff checked for penetrations above all the fire doors. No other penetrations were found. 3. To ensure that all penetrations are sealed and caulked penetrations will be added to the monthly checks of the maintenance staff beginning 6/26/13. 4. Beginning 6/26/13 the maintenance manager will report outcomes of the monthly check to the monthly QAPI committee and the Administrator will ultimately communicate to the governing body at their meeting.	07/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	administrator	7/19/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUL 22 2013

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K 017	Continued From page 1 during the exit conference on June 10, 2013.	K 017		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure all exit discharges were accessible. The findings include: Observation on June 6, 2013 at 11:30 a.m. revealed that the wing 4 dining room exit discharge from the building did not have a sidewalk to lead to the public way. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on June 10, 2013.	K 038	1. On 7/15/2013 contracted service added a concrete sidewalk the full length of wing 4 west hall starting at the exterior exit in the wing 4 dining room. 2. Exterior doors were checked and they had hard surface leading to the public way. No sidewalks were identified as needing repair or additions. 3. Facility sidewalks will be included on the quarterly environmental rounds that are conducted by maintenance staff. Any identified areas for improvement will be reported to the Administrator. 4. Beginning July 2013, the maintenance manager will report any exterior exit sidewalk not constructed of a hard surface or any sidewalk needing repair to the quarterly QAPI committee and ultimately the Administrator will report to the governing body.	07/19/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the sprinkler system.	K 062	1. On 6/20/13 and 6/21/13 contracted service performed a 5 year obstruction investigation test and a 5 year replacement test on the sprinkler system. 2. On 6/20/13 and 6/21/13 the contracted service checked the sprinkler system and found no obstruction and replaced 3 gauges. 3. The 5 year obstruction investigation test and the 5 year replacement test will be added to the 5 year preventative maintenance list located in the maintenance director's office.	07/19/13

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K 062	Continued From page 2 The findings include: Record review and interview with the maintenance director on June 10, 2013 at 10:15 a.m. revealed the following sprinkler deficiencies: 1. No documentation showing the 5 year obstruction investigation test has been performed within the last 5 years. 2. No documentation showing the 5 year gages replacement or calibration has been done within the last 5 years. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on June 10, 2013.	K 062	4. Beginning 7/10/13 the maintenance manager will report the outcomes of the obstructive investigative test and the replacement test to the QAPI committee and the Administrator will ultimately communicate to the governing body at his meeting.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their heating, ventilating, and air conditioning (HVAC). The findings include: Observation and interview with the maintenance director on June 10, 2013 at 10:30 a.m. revealed that the facility failed to inspect and test all fire dampers in the facility.	K 067	1. On July 2, 3, 10, 15,& 16 2013 contracted services inspected the fire dampers throughout the building. 2. On July 2, 3, 10, 15 & 16 2013 contracted services repaired damper parts found to be malfunctioning. 3. To ensure that fire dampers are checked every 4 years, the maintenance director will add to the 4 year preventative maintenance log. 4. Beginning 7/17/13 the maintenance manager will report fire damper checks to the monthly QAPI committee and the Administrator will ultimately communicate to the governing body at his meeting.	07/19/13

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K 067	Continued From page 3 This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on June 10, 2013.	K 067	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's creditible allegation of compliance.	